

Correspondence

The Editorial Board will be pleased to receive and consider for publication correspondence containing information of interest to physicians or commenting on issues of the day. Letters ordinarily should not exceed 600 words, and must be typewritten, double-spaced and submitted in duplicate (the original typescript and one copy). Authors will be given an opportunity to review any substantial editing or abridgement before publication.

Curanderismo

TO THE EDITOR: The recent, excellent article by Mull and Mull entitled "A Visit With a *Curandero*" demonstrated the importance of folk healers among the Mexican-American population of the Southwest border areas.¹ As a family physician who practiced along the California-Mexican border in the 1970s, I learned firsthand that such traditional healers were popular, and I am now discovering that they are equally important in the Mexican-American barrios of Chicago.

However, I believe that because of the great geographic distance of Chicago from the Mexican border, *curanderos* may take on an additional role here. The corridor along the United States-Mexican border has become a true bicultural zone, hence recent Mexican immigrants can easily blend and feel culturally comfortable in their new environment, or if feeling threatened, can easily return to visit home villages in Mexico for a cultural rejuvenation. Chicago, with its multiethnic composition, often appears culturally foreign to new Mexican immigrants in spite of the fact that it has the third largest Hispanic population in the country. In this changed social environment, which lacks a visible resemblance to their mother country, many Mexicans may believe that they are losing their ethnic identity and becoming acculturated. Masden states that such individuals who are involved in such a cultural transfer are called *Inglesados* (the anglicized) or *agringados* (the "gringoized") by the more conservative Latins.²

The anxieties and guilt produced by such acculturation pressures can provide the genesis for many psychosomatic symptoms or common folk diseases. Thus the *curandero* in Chicago offers relief not only by accepting and treating these symptoms as a valid folk illness, but by also providing the anxious and perhaps confused immigrant with an instant cultural infusion. By seeking care from a traditional folk healer, the attention of the person is immediately focused on the values of Mexican culture, thereby affording to those who feel they are losing their cultural identity an opportunity to reaffirm those traditional values.

Folk medicine will continue to be of importance in this country as present immigration patterns increase. Physicians who elect to practice among Mexican-Americans should be aware of *curanderismo*, or folk

medicine, if they want to truly understand their patients.³ The Western medical model teaches that disease is an abnormality in the structure and function of body organs. Cross-cultural medicine teaches us that illness represents personal and interpersonal reactions to the disease or discomfort. As physicians, we should be aware of both.

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2. Masden W: Value conflicts in folk psychotherapy in south Texas, In Kiev A (Ed): Magic, Faith and Healing. New York, The Free Press, 1964
3. Kiev A: Curanderismo—Mexican-American Folk Psychiatry. New York, The Free Press, 1968

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TO THE EDITOR: The *Western Journal of Medicine's* visit with a *curandero*¹ was a refreshing experience for me. I read it at breakfast as I relaxed after a busy morning in the emergency department.

At dawn a young Chinook lady had appeared, blood-spattered and worn out from alcohol and physical abuse. Her complaints of chronic pain in the occiput, the chest and the abdomen were evaluated and addressed. I wished for the wisdom of a Chinook medicine man to aid this young Amerind woman as she floundered painfully in our white world; I settled for calling the alcoholism counselor.

As she passed out of my hands I turned to a man with chest pain. He had a culturally familiar disease with which I was more comfortable, and we were successful in treating his ventricular fibrillation.

Some observations regarding those of us in the healing professions are as follows:

- Our power is often invoked from outside ourselves. The *curandero* calls upon God, I upon biomedical techniques.
- We have our respective strengths. We Western physicians are better at ventricular fibrillation, the *curandero* at *susto*.
- We each have weaknesses. Mr Flores, the *curandero*, refers suspected cases of appendicitis. I would have liked to refer the blood-spattered young Amerind woman to an effective Chinook medicine man.

I would like to make a plea: We in Western medicine

are successful in a circumscribed arena. Outside that arena lies much suffering over which we are powerless. The *curandero* and other healers have gifts that complement ours.

Let us join with the competent health care providers of other cultures to share our knowledge and skills.

Since we take it upon ourselves to regulate the *curandero*, let us invite competent representatives of these practitioners to sit on our regulatory boards.

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1. Mull JD, Mull DS: A visit with a *curandero* (Cross-cultural Medicine). West J Med 1983 Nov; 139:730-736

Management of Diabetes Mellitus

TO THE EDITOR: Dr Siperstein's remarks in the conclusion of a recent Medical Staff Conference in this journal discussing hypoglycemia¹ require some amplification to put the question of whether tight control is beneficial for diabetic complications into its proper perspective. First, there is *not* good evidence that the large vessel complications of stroke, myocardial infarction or peripheral vascular disease are helped by tight control. However, there is *very* good evidence that the small vessel complications of retinopathy and nephropathy and the neuropathic changes are delayed. In addition to the overwhelming amount of animal data,² there are several prospective human studies that document that the onset and progression of these complications are slowed by tight diabetic control.^{3,4} One of these,⁵ in which more than 4,000 patients were followed for up to 25 years, is particularly convincing. Furthermore, more recent evidence shows that tight diabetic control is associated with reversal of some of the early changes of these complications such as basement membrane thickness,^{4,6} leakage of fluorescein dye from retinal vessels,⁴ urinary excretion of small amounts of albumin,⁴ abnormal tests of retinal function,⁴ decreased nerve conduction velocity⁴ and the pain of sensory neuropathy.⁴ However, it is becoming clear that the more established renal⁷ and morphological retinal^{4,8} changes may not be helped by strict diabetic control. These latter observations emphasize the importance of instituting tight control before these complications become manifest rather than ignoring all of the positive evidence simply because in some instances it is too late to remedy the situation.

Since maintenance of strict diabetic control requires close attention to diabetes care by both patients and their physicians, the rationale for carrying out this approach needs to be firmly established. Therefore, let us examine the references cited to question the positive effects of lower glucose concentrations on these diabetic complications. One study⁹ showed progression of the already established morphological changes of retinopathy even as the indices of retinal function improved in a group of patients whose diabetic control was much better than a control group, both of whom were studied prospectively for one year. In a second study,¹⁰ there

was little difference in glycosylated hemoglobin (HbA_{1c}) values at the end of the two-year period between the multiple-insulin-injection group and the conventionally treated patients although the differences at 8 and 12 months did achieve statistical significance. In spite of the lack of a large difference in HbA_{1c} values, the patients receiving multiple injections of insulin showed an improvement in sensory nerve function, no change in plasma creatinine concentrations and a small decrease in creatinine clearance. The conventionally treated group showed decreased sensory nerve function, increased plasma creatinine levels and a much greater decrement in creatinine clearance. The differences in the changes in these three measurements between the two groups were all statistically significant. However, there was no difference in the retinal changes between the two groups during this period. A third study¹¹ describes the detailed morphological retinal changes in the report cited above.⁷

The remaining three references do not really speak to a possible lack of efficacy of tight control on diabetic complications. One¹² described the counter regulatory hormonal responses to hypoglycemia in patients with type 1 diabetes and the pattern of glucose recovery. A second¹³ summarized the metabolic abnormalities in diabetes and cautions against the possible consequences of hypoglycemia. The third¹⁴ showed that the insulin-treated group of type 2 diabetic patients in the University Group Diabetes Program study fared no better than the patients receiving either placebo or homeopathic doses of insulin. However, all of these patients had relatively mild diabetes (some would now be classified as having impaired glucose tolerance), the fasting blood glucose level was approximately 120 mg per dl in the insulin-treated patients and only 160 mg per dl in the two control groups and, most important, "serious microvascular complications were surprisingly low" in all groups during the ten-year period of the study. The latter observation is consistent with a large number of these patients having impaired glucose tolerance and not being suitable for studying the effect of control on microvascular complications.

Thus, it seems pretty well established that strict diabetic control is beneficial for retinopathy, nephropathy and neuropathy. With home glucose monitoring and either multiple-insulin-injection regimens or, in selected patients, insulin pump therapy, the means to achieve strict control are available. However, patients who attain near-normal glucose concentrations often have mild hypoglycemic reactions several times a week. The difficult questions are what level of control is necessary and is it possible to achieve it without serious hypoglycemia? The glucagon response to hypoglycemia has recently been shown to be absent in patients with type 1 diabetes soon after the diagnosis.^{15,16} Furthermore, the other important counterregulatory hormone, epinephrine, may also be diminished in some patients even in the absence of clinical manifestations of autonomic neuropathy.^{15,16} These observations lend special